State of Washington
Department of Labor and Industries

Payment Policies

for Services Provided to Injured Workers and Victims of Crime

Effective August 1, 2003

This document is available in alternative formats to accommodate persons with disabilities. For assistance, call 1-800-547-8367. (TDD/TTY users, please call 360-902-5797). Labor and Industries is an Equal Opportunity employer.

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Highlights of Changes

This *Medical Aid Rules and Fee Schedules (*fee schedule) is effective for services provided on or after August 1, 2003. These highlights are intended for general reference; they are not a comprehensive list of all the changes in the fee schedule. Refer to the 2003 CPT© and HCPCS coding books for complete code descriptions and lists of new, deleted or revised codes.

WASHINGTON ADMINISTRATIVE CODE (WAC) AND PAYMENT CHANGES

- Cost of living adjustments were applied to RBRVS and anesthesia services and to most local codes.
- WAC 296-20-135 increased the RBRVS conversion factor from $50.51 to $50.58 and increased the anesthesia conversion factor from $2.78 per minute ($41.70 per 15 minutes) to $2.80 per minute ($42.00 per 15 minutes).
- WAC 296-23-220 and WAC 296-230 increased the maximum daily cap for physical and occupational therapy services to $103.65.

POLICY ADDITIONS, CHANGES AND CLARIFICATIONS

Professional Services

- Added section: Spinal Injection Policy
- The department no longer covers apheresis services. Apheresis is not used to treat industrial injuries or occupational diseases.
- The department will cover autologous chondrocyte implants when the criteria outlined in Provider Bulletin 03-02 are met.
- The department will cover meniscal allograft transplantations when the criteria outlined in Provider Bulletin 03-02 are met.
- Audiology services have been revised.
- Home Health Care services have been revised to reflect the new emphasis upon agency care.
- Vocational Services have been revised to implement recent rule changes.

Appendices

- Added and revised Appendix H, Documentation Requirements

Fee Schedules

- Local codes have been added to the fee schedule section.

Introduction

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules*, *Provider Bulletins*, and *Provider Updates*. If there are any services, procedures, or text contained in the CPT® and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies apply (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

INTRODUCTION CONTENTS

GENERAL INFORMATION

EFFECTIVE DATE

This edition of the *Medical Aid Rules and Fee Schedules* is effective for services performed on or after August 1, 2003.

UPDATES AND CORRECTIONS TO THE FEE SCHEDULES

If necessary, corrections to the *Medical Aid Rules and Fee Schedules* will be published on the department's web site at www.LNI.wa.gov/hsa/

Additional fee schedule and policy information is published throughout the year in the department's *Provider Bulletins* and *Provider Updates* that are located on the department's web site at www.LNI.wa.gov/hsa/

STATE AGENCIES' FEE SCHEDULE AND PAYMENT POLICY DEVELOPMENT

The Washington state government payers coordinate fee schedule and payment policy development. The intent of this coordination is to develop payment systems and policies that make billing and payment requirements as consistent as possible for providers.

The state government payers are:

- The Washington State Fund workers' compensation program (The State Fund), administered by the Department of Labor and Industries
- The Uniform Medical Plan, administered by the Health Care Authority for state employees and retirees
- The State Medicaid Program, administered by the Medical Assistance Administration (MAA) within the Department of Social and Health Services (DSHS)

These agencies comprise the Interagency Reimbursement Steering Committee (RSC). The RSC receives input from the State Agency Technical Advisory Group (TAG) on the development of fee schedules and payment policies. The TAG consists of representatives from almost all major state professional provider associations.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own source of funding, benefit contracts, rates and conversion factors.

BECOMING A PROVIDER

WORKERS' COMPENSATION PROGRAM

A Provider must have an active L&I provider account number to receive payment for treating a Washington injured worker.

Providers can apply for account numbers by completing a Provider Account Application and Form W9 available at www.LNI.wa.gov/forms (form #F248-011-000 & #F248-036-000) or can be requested by contacting the department's Provider Accounts section or the Provider Hotline at 1-800-848-0811.

Provider Accounts	Provider Hotline
Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261 (360) 902-5140	1-800-848-0811

More information about the provider application process is published in WAC 296-20-12401, which can be found in the Medical Aid Rules section.

CRIME VICTIMS COMPENSATION PROGRAM

Providers treating victims of crime must apply for separate accounts with the Crime Victims Compensation Program. Provider applications for the Crime Victims Compensation Program are available on the department's web site at www.LNI.wa.gov/forms (form #F800-053-000) or can be requested by contacting the Crime Victims Compensation Program.

Department of Labor and Industries
Crime Victims Compensation Program
Provider Registration
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716

BILLING INSTRUCTIONS AND FORMS

BILLING PROCEDURES

Billing procedures are outlined in WAC 296-20-125, which can be found in the Medical Aid Rules section.

BILLING MANUALS AND BILLING INSTRUCTIONS

The General Provider Billing Manual (publication #F248-100-000) and the department's provider specific billing instructions contain billing guidelines, reporting and documentation requirements, resource lists and contact information. These publications can be requested from the department's Provider Accounts section or the Provider Hotline. (Refer to "Becoming a Provider" above for contact information.)

BILLING FORMS

Providers should use the department's most recent billing forms. Using out-of-date billing forms may result in delayed payment. To order new billing forms or other department publications, complete the Medical Forms Request (located at the end of this document or on the department's web site at www.LNI.wa.gov/forms) and send it to the department's warehouse.

GENERAL BILLING TIPS

This symbol is placed next to billing tips throughout the policy sections to facilitate correct payments.

SUBMITTING CLAIM DOCUMENTS TO THE STATE FUND

Mailing State Fund bills, reports and correspondence to the correct addresses helps the department pay you promptly.

Billing Tip

Reports and chart notes should be mailed separately from bills. Sending reports or chart notes with your bill may delay or even prevent the information from reaching the claims manager.

Item	State Fund Mailing Address
Report of Industrial Injury or Occupational Disease	Department of Labor & Industries PO BOX 44299 Olympia, WA 98504-4299
Correspondence, reports and chart notes for State Fund Claims and for claim related documents other than bills.	Department of Labor & Industries PO BOX 44291 Olympia, WA 98504-4291
State Fund Provider Account Information Updates	Department of Labor & Industries PO BOX 44261 Olympia, WA 98504-4261
UB-92 Form	Department of Labor & Industries PO BOX 44266 Olympia, WA 98504-4266
Adjustments and Bills for Retraining & Job Modification, Home Nursing and Miscellaneous	Department of Labor & Industries PO BOX 44267 Olympia, WA 98504-4267
Bills for Pharmacy & Compound Prescriptions	Department of Labor & Industries PO BOX 44268 Olympia, WA 98504-4268
HCFA 1500 Form	Department of Labor & Industries PO BOX 44269 Olympia, WA 98504-4269
State Fund Refunds (attach copy of remittance advice)	Department of Labor & Industries Cashier's Office PO BOX 44835 Olympia, WA 98504-4835

TIPS FOR SUBMITTING DOCUMENTS TO THE STATE FUND

The State Fund uses an imaging system to store electronic copies of all documents submitted on injured workers' claims. This system cannot read some types of paper and has difficulty passing other types through automated machinery.

Do's

Following these tips can help the department process your documents promptly and accurately.

- Submit documents on white 8 ½ x 11- inch paper (one-side only).
- Leave ½ inch at the top of the page blank.
- Submit legible information.
- Put the patient's name and claim number in the upper right hand corner.
- If no claim number substitute the patient's social security number
- Emphasize text with asterisks or underlines.
- Staple together all documents pertaining to one claim.
- Include a key to any abbreviations used.
- Reference only one worker/patient in a narrative report or letter.

Don'ts

Please do not submit information in the following manner.

- Don't use colored paper, particularly "hot" or intense colors.
- Don't use thick or textured paper.
- Don't send carbonless paper.
- Don't use any highlighter markings.
- Don't place information within shaded areas.
- Don't use paper with black or dark borders, especially on the top border.
- Don't staple documents for different workers/patients together.

Following the above tips can prevent significant delays in claim management and bill payment and can help you avoid department requests for information you have already submitted.

DOCUMENTATION REQUIREMENTS

Providers must maintain documentation in workers' medical files to verify the level, type and extent of services provided to injured workers. The department may deny or reduce a provider's level of payment for a specific visit or service if the required documentation is not provided or the level or type of service does not match the procedure code billed. No additional amount is payable for documentation required to support billing.

In addition to the documentation requirements published by the American Medical Association in the physicians' Current Procedural Terminology, CPT® book, the department or Self-Insurer has additional reporting and documentation requirements. These requirements are described in the provider specific sections and in WAC 296-20-06101. The department may pay separately for specialized reports or forms required for claims management. For specific documentation requirements see **Appendix H**.

RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with the department, you are the legal custodian of the injured workers' medical records. You must include subjective and objective findings, records of clinical assessment (diagnoses), as well as reports and interpretations of x-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for the department to audit the provision of services for a minimum of five years *(See WAC 296-20-02005 Keeping of record*s).

Providers are required to keep all x-rays for a minimum of ten years *(See WAC 296-23-140 Custody of x-rays).*

CHARTING FORMAT

For progress and ongoing care, use the standard "SOAP" (Subjective, Objective, Assessment, Plan and progress) format. In worker's compensation there is a unique need for work status information. To meet this need it is suggested adding "ER" to the SOAP contents. Chart notes should document employment issues, including a record of the patient's physical and medical ability to work, and information regarding any rehabilitation that the worker may need to undergo. Restrictions to recovery, any temporary or permanent physical limitations, and any unrelated condition(s) that may impede recovery must be documented.

"SOAP-ER"

S Subjective complaints.

O Objective findings.

A Assessment.

P Plan and progress.

E Employment issues.

R Restrictions to recovery.

OVERVIEW OF PAYMENT METHODS

HOSPITAL INPATIENT PAYMENT METHODS

The following is an overview of the department's payment methods for services in the hospital inpatient setting. Refer to Chapter 296-23A in the *Medical Aid Rules* and the Hospital Payment Policies section for more information.

All Patient Diagnosis Related Groups (AP-DRG)

The department uses All Patient Diagnosis Related Groups (AP-DRGs) to pay for most inpatient hospital services.

Percent of Allowed Charges (POAC)

The department uses a POAC payment method for some hospitals that are exempt from the AP-DRG payment method.

Self-insurers and Crime Victims pay all hospitals using POAC.

The department uses the POAC as part of the outlier payment calculation for hospitals paid by the AP-DRG.

Per Diem

The department uses statewide average per diem rates for five AP-DRG categories: chemical dependency, psychiatric, rehabilitation, medical, and surgical. Some hospitals are paid for all inpatient services using per diem rates. Hospitals paid using the AP-DRG method are paid per diem rates for AP-DRGs designated as low volume.

HOSPITAL OUTPATIENT PAYMENT METHODS

The following is an overview of the department's payment methods for services in the hospital outpatient setting. Refer to Chapter 296-23A in the *Medical Aid Rules* and the Hospital Payment Policies section for more detailed information.

Ambulatory Payment Classifications (APC)

The department pays for most hospital outpatient services with the APC payment method.

Professional Services Fee Schedule

The department pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

Self-insurers and Crime Victims pay for most radiology, pathology, laboratory, physical therapy, and occupational therapy services according to the maximum fees in the Professional Services Fee Schedule.

Percent of Allowed Charges (POAC)

Hospital outpatient services that are not paid with the APC payment method, the Professional Services Fee Schedule or by department contract are paid by a POAC payment method.

Self-insurers and Crime Victims use POAC to pay for hospital outpatient services that are not paid with the Professional Services Fee Schedule.

AMBULATORY SURGERY CENTER PAYMENT METHODS

Ambulatory Surgery Center (ASC) Groups

The department uses a modified version of the ASC Grouping system that was developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC. Refer to Chapter 296-23B in the Medical Aid Rules and the ASC Payment Policies section for more information.

PROFESSIONAL PROVIDER PAYMENT METHODS

Resource Based Relative Value Scale (RBRVS)

The department uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. More information about RBRVS is contained in the Professional Services section. Services priced according to the RBRVS fee schedule have a fee schedule indicator of "R" in the Professional Services Fee Schedule.

Anesthesia Fee Schedule

The department pays for most anesthesia services using anesthesia base and time units. More information is available in the Professional Services section.

Pharmacy Fee Schedule

The department pays pharmacies for drugs and medications according to the pharmacy fee schedule. More information is available in the Professional Services section.

Average Wholesale Price

The department's rates for most drugs dispensed from a prescriber's office are priced based on a percentage of the average wholesale price (AWP) or the average average wholesale price (AAWP) of the drug. Drugs priced with an AWP or AAWP method have a fee schedule indicator of "D and/or "AWP" in the Dollar Value" columns " in the Professional Services Fee Schedule.

Clinical Laboratory Fee Schedule

The department's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by the Centers for Medicare and Medicaid Services. Services priced according to the department's clinical laboratory fee schedule have a fee schedule indicator of "L" in the Professional Services Fee Schedule.

Flat Fees

The department establishes rates for some services that are not priced with other payment methods. Services priced with flat fees have a fee schedule indicator of "F" in the Professional Services Fee Schedule.

Department Contracts

The department pays for some services by contract. Some of the services paid by contract include TENS units and supplies, utilization management, chronic pain management, and chemically related illness center services. Services paid by department agreement have a fee schedule indicator of "C" in the Professional Services Fee Schedule. Crime Victims does not contract for these services. Please refer to the appropriate Provider Bulletin for additional information.

By Report

The department pays for some covered services on a "by report" basis. Services paid by report have a fee schedule indicator of "N" in the Professional Services Fee Schedule.

BILLING CODES AND MODIFIERS

The department's fee schedules use the federal Healthcare Common Procedure Coding System (HCPCS), and agency unique "local codes."

HCPCS Level I codes are the Physicians' Current Procedural Terminology (CPT®) codes that are developed, updated and copyrighted annually by the American Medical Association (AMA). There are three categories of CPT® codes:

> **CPT® Category I** codes are codes used for professional services and pathology and laboratory tests. These services are clinically recognized and generally accepted services, not newly emerging technologies. These codes consist of five numbers (e.g. 99201).
>
> **CPT® Category II** codes are optional codes used to facilitate data collection for tracking performance measurement. These codes consist of four numbers followed by the letter "F" (e.g. 1234F).
>
> **CPT® Category III** codes are temporary codes used to identify new and emerging technologies. These codes consist of four numbers followed by the letter "T" (e.g. 0001T).

HCPCS Level I modifiers are the CPT® modifiers that are developed, updated and copyrighted annually by the American Medical Association (AMA). CPT® modifiers are used to indicate that a procedure or service has been altered without changing its definition. These modifiers consist of two numbers (e.g. -22). The department does not accept the five digit modifiers.

HCPCS Level II codes, commonly called HCPCS (pronounced "Hick-Picks"), are updated annually by the Centers for Medicare and Medicaid Services (CMS). CMS develops most of the codes. Codes beginning with "D" are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3). HCPCS codes are used to identify miscellaneous services, supplies and materials not contained in the CPT® coding system. These codes begin with a single letter, followed by four numbers (e.g. K0007).

HCPCS Level II modifiers are developed and updated annually by CMS and are used to indicate that a procedure has been altered. These modifiers consist of two letters (e.g. -AA) or one letter and one number (e.g. -E1).

Local codes are used to identify department unique services or supplies. They consist of four numbers followed by one letter (except "F" and "T"). For example, 1040M should be used to code completion of the department's accident report form. The Health Insurance Portability and Accountability Act (HIPAA) may alter the use of some local codes.

Local modifiers are used to identify department unique alterations to services. They consist of one number and one letter (e.g. –1S). The Health Insurance Portability and Accountability Act (HIPAA) may alter the use of some local modifiers.

The fee schedules do not contain the full text descriptions of the CPT®, HCPCS, or CDT codes. Providers must bill according to the full text descriptions published in the CPT® and HCPCS books, which can be purchased from private sources. Refer to Washington Administrative Code (WAC) 296-20-010(1) for additional information.

REFERENCE GUIDE FOR CODES AND MODIFIERS

	HCPCS Level I			HCPCS Level II	
	CPT® Category I	**CPT® Category II**	**CPT® Category III**	**HCPCS**	**L&I Local Codes**
Source	AMA/ CMS	AMA/ CMS	AMA/ CMS	CMS/ ADA	Labor & Industries
Code Format	5 numbers	4 numbers followed by "F"	4 numbers followed by "T"	1 letter and 4 numbers	4 numbers and 1 letter (not "F" or "T")
Modifier Format	2 numbers	N/A	N/A	2 letters or 1 letter and 1 number	1 number and 1 letter
Purpose	Professional services & pathology & laboratory tests	Tracking codes to facilitate data collection	Temporary codes for new and emerging technologies	Materials, supplies, drugs & professional services	L&I unique services, materials & supplies

PROVIDER BULLETINS AND UPDATES

Provider Bulletins and Provider Updates are adjuncts to the *Medical Aid Rules and Fee Schedules*, providing additional fee schedule, medical coverage decisions, and policy information throughout the year.

Provider Bulletins give official notification of new or revised policies, programs and/or procedures that have not been previously published.

Provider Updates give official notification of corrections or important information, but the contents do not represent new policies, programs, and/or procedures.

All users of the *Medical Aid Rules and Fee Schedules* are encouraged to keep Provider Bulletins and Updates on file. The bulletins and updates listed below were in effect at the time this fee schedule was printed.

Provider Bulletins are available on the department's web site at www.LNI.wa.gov/hsa If you need hard copies, you may request them from the Provider Hotline at 1-800-848-0811.

If a bulletin or update is not listed here, it is either no longer current or has been incorporated into the *Medical Aid Rules and Fee Schedules*. Refer to the body of the *Medical Aid Rules and Fee Schedules* for changes affecting your practice.

CURRENT PROVIDER BULLETIN LIST

Bulletin Number	Date Issued	Subject	Contact Person	Phone Number
03-03	03/03	Psych Guidelines	LaVonda McCandless	360-902-6163
03-02	02/03	Coverage Decisions for Autologous chondrocyte implant Meniscal allograft transplant Computerized prosthetic knee UniSpacer	Grace Wang	360-902-5227
03-01	01/03	Interpreter Services	Paulette Golden	360-902-6299
02-12	12/02	Rating Permanent Impairment	Jami Lifka	360-902-4941
02-11	12/02	Neurontin	LaVonda McCandless	360-902-6163
02-07	10/02	Voc Rehab & Claims Information	Roy Plaeger-Brockway	360-902-6699
02-06	7/02	Spinal Injection Policy	Lee Glass	360-902-4256
02-05	5/02	Hospital Outpatient Prospective Payment System Device Payment Pass Through Payment Update	Jim King	360-902-4244
02-04	4/02	Utilization Review Program – New UR Firm	Nikki D'Urso	360-902-5034
02-03	4/02	HIPAA Impacts on Labor & Industries	Simone Stilson	360-902-5384 360-902-6319
02-01	3/02	Guidelines for Shoulder Surgeries	Lavonda McCandless	360-902-6690

Bulletin Number	Date Issued	Subject	Contact Person	Phone Number
01-14	12/01	Recent Formulary Coverage Decisions and Drug Updates	Jaymie Mai	360-902-6792
01-13	11/01	Hospital Outpatient Prospective Payment System	Jim King	360-902-4244
01-12	11/01	Ambulatory Surgery Center Payment	Amy White	360-902-6800
01-11	11/01	Transcutaneous Electrical Nerve Stimulation (TENS)	Susan Christiansen	360-902-6821
01-08	8/01	Payment Policies for Attendant Services	Jim Dick	360-902-5131
01-07	8/01	Chiropractic Consultant Program	Joanne McDaniel	360-902-6817
01-06	6/01	Testing and Treatment of Bloodborne Pathogens	Jamie Lifka	360-902-4941
01-05	6/01	Guidelines for Lumbar Fusion (Arthrodesis)	Lavonda McCandless	360-902-6690
01-04	5/01	Vocational Provider Performance Measurement	Jim Kammerer Mary Kaempfe	360-902-6809 360-902-6811
01-03	5/01	Vocational Rehabilitation Payment Guidelines	Blake Maresh	360-902-6564
01-01	2/01	Vocational Rehabilitation Purchasing	Blake Maresh	360-902-6564
00-09	10/00	IDET & Vax-D	Grace Wang	360-902-5227
00-08	7/00	UR Program	Nikki D'Urso	360-902-5034
00-06	5/00	Outside of Washington State Provider Reimbursement Policies	Tom Davis Jim King	360-902-6687 360-902-4244
00-04	5/00	Payment for Opioids to Treat Chronic, Noncancer Pain	Jami Lifka	360-902-4941
99-11	12/99	Job Modification and Pre Job Accommodations	Karen Jost	360-902-5622
99-06	7/99	Pharmacy On-Line Point-of-Service Billing System	Tom Davis	360-902-6687
99-04	6/99	Physician Assistant Provider Numbers	Tom Davis	360-902-6687
99-02	5/99	Review for Job Analysis	Dave Erickson	360-902-4477
98-11	12/98	Fibromyalgia	Jami Lifka	360-902-4941
98-10	12/98	Hyaluronic Acid in Treatment of Osteoarthritis of the Knee	Jami Lifka	360-902-4941
98-09	9/98	Authorizing Vocational Retraining: Policies 6.51, 6.52 & 6.53	Dave Erickson	360-902-4477

Bulletin Number	Date Issued	Subject	Contact Person	Phone Number
98-07	6/98	Payment for Job Analysis Review	Jim King	360-902-4244
98-04	6/98	Post-Acute Brain Injury Rehabilitation Reimbursement Policy	Jim King	360-902-4244
98-03	5/98	Cover Sheet Required for Voc Closing Reports	Peri Smith	360-902-5150
98-02	4/98	Post-Acute Brain Injury Rehabilitation Coverage Policy	Lucille Lapalm RN, ONC	360-902-4293
98-01	2/98	Payment Policy for Nurse Case Management	Pat Patnode RN, ONC	360-902-5030
97-05	10/97	Complex Regional Pain Syndrome (CRPS)	Lavonda McCandless	360-902-6690
97-04	7/97	Neuromuscular Electrical Stimulation (NMES) Device	Grace Wang	360-902-5227
97-03	7/97	Obesity Treatment Policy 7.13	Pat Patnode RN, ONC	360-902-5030
96-11	11/96	Home Modification Policy 11.10	Karen Jost	360-902-5622
96-10	10/96	Exchanging Medical Information with Employers	Sandy Dziedzic	360-902-4471
96-07	6/96	Osteopathic Payment Policy & Billing Information	Tom Davis	360-902-6687
95-10	11/95	Guidelines for Electrodiagnostic Evaluation of Carpal Tunnel	Lavonda McCandless	360-902-6690
95-08	10/95	Introducing the Center for Excellence for Chemically Related Illness	Dave Overby	360-902-6791
95-04	4/95	Thoracic Outlet Syndrome	Lavonda McCandless	360-902-6690
94-16	6/94	Home Health Care, Home Care and Hospice Agencies	Lucille Lapalm RN, ONC	360-902-4293
94-12	2/94	Revised Rules for the Evaluation of Respiratory Impairment	Jami Lifka	360-902-4941
93-02	4/93	Pain Clinics	Carole Winegar	360-902-6815
91-01	1/91	Screening Criteria for Surgery to Treat Knee Injuries	Lavonda McCandless	360-902-6690

CURRENT PROVIDER UPDATE LIST

Update Number	Date Issued	Subject	Contact Person	Phone Number
02-03	12/02	Winter Voc Update	Roy Plaeger-Brockway	360-902-6699
02-02	11/02	Fall Voc Update	Roy Plaeger-Brockway	360-902-6699
02-01	5/02	Spring Voc Update	Mary Kaempfe	360-902-6811
01-02	11/01	Vocational Services	Joanne McDaniel	360-902-6817
01-01	11/01	Miscellaneous Topics: Provider Documentation and Reporting Requirements; Information Release Form; Rebill State Fund; Submitting Claim Documents to State Fund; Ergonomics Rule; Fee Schedule Corrections; Independent Medical Examination Report, Intradiscal Electrothermal Technique; Place Of Service Coding; Work-Related Asthma	Joanne McDaniel	360-902-6817
00-01	1/00	Miscellaneous Topics: Submitting Claims; Hearing Aids; IMEs; Personal Appliances; Plantar Fasciitis; Prescriptions; Provider On-Line Services; Billing for Multiple, Same-Day Surgery Services; Toll Free Lines; Work Conditioning and Work Hardening	Joanne McDaniel	360-902-6817
99-01	6/99	Miscellaneous Topics: Current Staff Addresses; Chiropractic Fee Schedule Clarification; Dry Hydrotherapy; Hearing Aids; Medical Examiners' Handbook; Medical Reimbursement Methods Evaluation Project; Outpatient Prospective Payment System Project; Post-Acute Head Injury Program; TENS	Joanne McDaniel	360-902-6817
98-02	9/98	Miscellaneous Topics: Current Staff Addresses; Chiropractic Consultant program; Hearing Aid Replacement; Post-Acute Brain Injury Rehabilitation; Ultram prescriptions	Joanne McDaniel	360-902-6817
96-02	10/96	Errors the Department Frequently Identifies during Audits and Reviews	Joanne McDaniel	360-902-6817